REMARKS OF
CONGRESSMAN HENRY A. WAXMAN
CHAIRMAN
SUBCOMITTEE ON HEALTH AND THE ENVIRONMENT

TO THE
COLLEGE OF AMERICAN PATHOLOGISTS
23 FEBRUARY 1990

Good morning, and thank you for the invitation to talk to you about the Subcommittee's agenda for this year. As we approach the month of March, we already have a very busy schedule of hearings and mark-ups, from AIDS to Clean Air legislation.

ACCESS TO HEALTH CARE

Let me start out by talking about the health care issue that I think is weighing most on the minds of Americans -- the issue of access to affordable health care. I'd like to give you a sense of the broad scope of the problem as I see it.

Between 31 and 37 million people in this country -- 13 to 18 percent of the nonaged population -- are uninsured. Of those, 80 percent are workers or their families.

I know you've heard these figures before, but let me say that again: In our job-based health care system, 25 to 28 million gainfully employed Americans and their spouses and their children have no health care coverage whatsoever.

Or look at it another way. Between 8 and 10 million children -- 13 to 16 percent of all kids -- are uninsured. No private coverage. No Medicaid. These are the kids who will be the work force when I and most of you are on Social Security. We are making no investment in their health. Among our international competitors, only South Africa is so shortsighted.

This situation makes no sense---not for the people without coverage, not for the productivity of our work force, not for the impact on our health care system and providers.

Even for people who have been covered---or think they are covered, there are problems. The small business insurance market is collapsing. Many insurers are blacklisting certain types of small businesses and professions. And, often people working for small businesses who have been covered, once they get sick, find their premium rates skyrocketing after the first serious illness. People are arbitrarily dropped in the time of real need. Small businesses simply cannot buy a good health insurance plan at a fair price for their employees and have any confidence that it will still be in force when it's needed.

We've spent the last ten years waiting for the invisible hand of the marketplace to solve these problems by itself. But things have only gotten worse. If we are ever to solve these problems, Government is going to have to play a major role.

Just what that role should be is the basic question facing the U.S. Bipartisan Commission on Comprehensive Health Care. The charge of the Pepper Commission is to report, by March 1st, on recommendations for policies that will assure all Americans access to basic health care coverage and access to coverage that provides them necessary long-term care and financial protection. I expect that report will help us significantly to achieve consensus on a legislative solution to this problem. I expect and hope the Commission's proposals will have many features in common with my own bill, the Basic Health Benefits Act.

But wherever the Commission comes out, I expect to work in my own Subcommittee to pass legislation if we can, and to focus public awareness on the issues that confront us even if we fall short of reporting a bill.

There are also a good many people that think that our health care costs in this country are out of control. This year we will spend $621 billion, or 10.7 percent of our GNP, on health care. If

current trends continue, by the year 2000, we will be spending $1.5 trillion or 14.1 percent of GNP on health care. Some say that is a reason not to take action. But when we spend those dollars and still have so many uninsured, and a health care system straining at the seams---well that argues to me that action is necessary.

MEDICARE

Turning to Medicare, I would like to recap briefly the progress we made last year and then discuss what I think our agenda will be this year.

Recapping last year

When I met with you last year at this time, I told you that we would try very hard to enact legislation creating an RB-RVS fee schedule, but the issue was still very much in doubt. As you well know, we did succeed in getting that legislation enacted, and on the whole, I am quite pleased with the result. There are a few things I would have done a little differently if I could, but the general structure and most of the details are consistent with the bill I introduced last year.

Although official implementation of the RB-RVS fee schedule does not begin until 1992, there are other changes which take effect this year, including the reductions in overvalued services and the higher increase for primary care services that contribute substantially to the transition to the RB-RVS fee schedule.

I will readily admit that I have reservations about the Volume Performance Standards -- or expenditure targets -- that are included in the bill. I believe we have the cart before the horse here, in holding the physician community accountable against a standard imposed immediately even though the information and tools needed for physicians to cope sensibly with such a standard will not be available for some time. Fortunately, the potential consequences of this policy were moderated substantially during

conference, in that we placed limits on the degree to which the statutory formulas could adversely affect future updates in physician fees.

I am particulary pleased with the provisions of the bill creating a new Agency for Health Care Policy and Research at the Public Health Service. The Agency's primary mission is to undertake health services research generally and research on the effectiveness of medical and surgical procedures, in particular. It is also given the important and delicate task of making sure that valid and clinically useful medical practice guidelines are developed for use by patients and physicians in making the most effective use of our health care dollars.

The creation of this new Agency and the enactment of the RB-RVS fee schedule, are the culmination of five years of effort by our Subcommittee in putting the pieces in place and building the political consensus for enactment.

This year's agenda

I expect our legislative products this year will not be nearly so monumental as last year. I do not see any major structural reforms in the offing. That does not mean, however, that our work this year will be unimportant.

As you have no doubt heard by now, the President has proposed $5.5 billion more in cuts for Medicare. This comes on top of over $40 billion in cuts over the last nine years. I assure you that it does not get easier with practice. This is simply too ambitious a target and I will do all I can to reduce it substantially.

Many of the President's proposals are ideas that the Congress has previously rejected. They haven't improved with age and I believe they should be rejected again.

Some of the President's other proposals revisit provisions we have enacted before, but would extend them or increase their

impact unreasonably. I don't like these proposals.

Nonetheless, I have no doubt that Medicare will be called upon to contribute significantly to deficit reduction again this year. Our subcommittee will work hard to make sure that provisions affecting physicians will, like those adopted in 1987 and 1989, be consistent with the RB-RVS reform. This means some further reductions in overvalued procedures and a full increase for primary care services.

Pathology fee schedule

I would like to take a moment to discuss with you our proposal to implement a pathology fee schedule beginning January 1, 1991.

This grew out of our discussions in 1987 about physician fee reform. I thought at that time it would be to your advantage to anticipate and resolve some of the issues, unique to pathology, that would arise during the creation and implementation of the RB-RVS fee schedule.

In the 1987 reconciliation bill, we asked the Secretary to develop a pathology fee schedule by April 1, 1989. The Secretary was not authorized to implement in the absence of further legislation.

The Secretary's fee schedule was not satisfactory, in large part because it was based on the existing, faulty charge base. Meanwhile, of course, the first round of the Hsiao study was completed, which also was unsatisfactory with respect to pathology services. I know that you have since commissioned Professor Hsiao to do a more expansive and valid anaylsis of pathology services.

Last year, I still believed it was to your advantage to have as much influence over the development of the fee schedule as possible. It was for that reason that we included the proposal in last year's reconciliation bill to begin a fee schedule on January 1, 1991. I realize you have serious reservations about that proposal. I

intend to discuss it carefully with you, with a view to making a decision very soon on whether to proceed with it or repeal the proposal and await the RB-RVS in 1992.

AIDS

Let me touch on a few other topics that should be of interest to you, the first being AIDS. People have a tendency to forget this, but we find ourselves in the midst of the worst epidemic in modern history. There are at least a million Americans infected, and over 60,000 have already died. Both because private insurers are screening these people out and because the disease disables people so quickly, Medicaid is becoming the predominant payor for AIDS care. And while Medicaid pays for the inpatient care of people who get acutely ill with AIDS, it won't pay for the preventive care to keep infected people from getting acutely ill.

I want to work on two specific AIDS provisions in this legislative year. First, and most pressing, we must find a way to get people to get tested, and -- if they are infected and immune-compromised -- begin early intervention drugs. If we can, we will save years of life and thousands of needless hospitalizations. We can do this by bringing people into the Medicaid system before they are completely disabled, and concentrating first on the kind of cost-efficient preventive care that will keep them healthy longer.

Second, we must improve Medicaid's reimbursement levels for hospitals that deal with a large number of AIDS patients. Everybody loses money on AIDS care. It's clear that AIDS patients in a hospital require additional of nursing care, lab tests, and ancillary services. Those hospitals who take care of a lot of AIDS patients lose a lot of money. If we expect to keep having hospitals available for such care, we must be prepared to pay more adequately for it. Otherwise, we risk losing our entire public hospital system under the growing burden of uncompensated AIDS care.

Starting with Subcommittee hearings next week, I plan to

focus attention on these proposals, and the remaining work that needs to be done to combat this epidemic.

DRUG TESTING

Let me talk about one final issue. I know you are interested in the status of H.R. 33, legislation introduced by Mr. Dingell to establish Federal certification standards for laboratories engaged in drug testing.

During the 100th Congress, legislation similar to H.R. 33 was included in the House version of Public Law 100-690, the "Anti-Drug Abuse Act of 1988." Unfortunately, differences between House and Senate conferees required that resolution of this important matter be deferred until the 101st Congress.

There is substantial diversity of opinion in Congress and within the general public about the role of urine drug testing. But regardless of one's feelings about drug testing generally, there is little disagreement that testing must be held to the highest scientific standards. When drug testing is conducted, attention to the accuracy of the test and the chain of custody must be scrupulously maintained.

This is a matter of public concern because an employee's job and personal reputation may rest on the outcome of a single urine screening. Testing must be done carefully if the basic rights of the employee to fairness and public confidence in the accuracy of drug testing are to be preserved. Unfortunately, the history of drug testing illustrates that mistakes have been made and some laboratories have engaged in shoddy scientific practices. As a result, careers have been jeopardized and personal reputations ruined.

It is in this spirit that the Subcommittee held hearings on H.R. 33 last year and hope action on the bill will be possible later this year.

CONCLUSION

These are just a few of the many issues we will have on the Subcomittee table this year. I expect that Clean Air legislation will occupy the majority of our time for the spring, and then we will be hard at work on Budget Reconcilation until adjournment. In between, I hope to make progress on legislation dealing with nutrition labeling, pesticides, and breast and cervical cancer, as well as a number of reauthorizations, including the Orphan Drug Act and the National Institutes of Health. It will be a busy, and I expect, a productive year.